Benefits Enrollment Form

2013 OPEN ENROLLMENT
RETIREE - HEALTH & DENTAL

City of Duluth - Human Resources
411 W. 1st Street • Room 313 • Duluth, Minnesota • 55802
218-730-5210 • Fax: 218-730-5906 • hrinformation@duluthmn.gov

Benefits Effective Date: 01/01/2013

All Open Enrollment forms must be returned to Human Resources (City Hall - Room 313) by 4:30 p.m. on Monday, November 26, 2012.

SECTION A: RETIREE / SURVIVOR INFORMATION

Full Name: _____ Social Security Number: _____

Mailing Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Email Address: _____

Home Phone: _____ Cell Phone: _____

Gender:
☐ Female
☐ Male

Marital Status:
☐ Single
☐ Married
☐ Widowed
☐ Legally Separated

SECTION B: HEALTH PLAN ELECTION - Comprehensive Hospital / Medical Benefit Plan 3A

Health Plan Election: ☐ Single ☐ Family

SECTION C: DENTAL PLAN ELECTION

Individuals electing Retiree + Spouse/Child or Family coverage shall maintain such coverage for not less than two (2) consecutive years.

Dental Plan Election: ☐ Retiree ☐ Retiree + Spouse ☐ Retiree + Child ☐ Family

Coverage Election:
☐ Low Option - $1,000 Annual Benefit
☐ High Option - $2,000 Annual Benefit

SECTION D: DEPENDENT INFORMATION

If you wish to add or cancel dependent coverage, you must complete this section.

Full Name of Dependent	Social Security No.	Date of Birth	Gender	Relationship to Retiree	Health	Dental
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel
					☐ Add ☐ Cancel	☐ Add ☐ Cancel

FOR INTERNAL USE ONLY: Payroll: _____ HealthPartners: _____ Delta Dental: _____ NPS: _____ Genesis SPM: _____

Retiree DB: _____ Auditor: _____ Health Group # 25077 _____ Dental Group # **000405-**_____ RX # **NPSCD P1**_____ Genesis QB: _____

SECTION E: ADDITIONAL INSURANCE INFORMATION (MEDICARE, MEDICAID, OR OTHER COVERAGE)

If you or any dependents covered are eligible for Medicare, Medicaid, and/or other insurance, complete this section.
Attach a copy of the card(s)

Full Name of Insured	**Coverage Type** (Medicare, Medicaid, or other insurance)	**Policy Number**	**Medicare Effective Date(s)**	
			Part A	**Part B**

SECTION F: AUTHORIZATION AND SIGNATURE

I hereby certify by my signature on the enrollment form that the foregoing information provided by me is true and correct, and that I have read and accept the conditions described in the enrollment material. I acknowledge having read the information provided to me and agree to all of the terms as defined by the plans I have selected, and I authorize the required deduction (if any) from my wages. By signing this form, I attest that I have reviewed the "Dependent Eligibility Requirements" and that the information I am submitting is true and accurate. I understand that providing false information or omission of relevant information on this form may result in the denial of claims, cancellation or rescission of coverage, and the City of Duluth or Duluth Joint Powers Enterprise Trust may be required to take action to recover funds expended due to fraud or fiscal misconduct. I also understand that it is my duty to notify the City of Duluth Human Resources Office of any changes provided by me on this form, including changes to the eligibility status of my dependents.

Signature	**Date**

Dependent Eligibility Requirements

Spouse

a.) Legally married opposite gender spouse; or
b.) Legally separated opposite gender spouse.

Dependent Child - birth through age 25 (up to the child's 26th birthday)

a.) An eligible child can include your unmarried or married biological child, legally adopted child or child placed for the purposes of adoption, foster child, stepchild or any other child state or federal law requires be treated as a dependent.
b.) A grandchild you claim as an exemption on your Federal income tax return and who is financially dependent upon you.
c.) A child of the subscriber who is required to be covered by reason of a Qualified Medical Child Support Order (QMCSO).